Connecticut Community KidCare/ HUSKY Behavioral Health Carve-Out

Rates and Fees

DEPARTMENT OF SOCIAL SERVICES
DEPARTMENT OF CHILDREN AND FAMILIES

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Introduction

The next phase of the implementation of Connecticut Community KidCare ("KidCare") entails a carve-out of the behavioral health benefits under the HUSKY program and the administration of those benefits under a contract with the Connecticut Community KidCare Administrative Service Organization ("KidCare ASO"). All providers of behavioral health services under the existing HUSKY program will have to enroll in the Department of Social Services' Connecticut Medical Assistance Program Network (CMAP), if not already enrolled, in order to continue receiving reimbursement for services rendered to HUSKY enrollees. With the exception of DCF funded residential services, claims will be processed by the Department of Social Services' Medicaid vendor, Electronic Data Systems (EDS). DCF residential payments will continue to be made through the LINK system. Enrollment in CMAP will not be required for DCF grant-funded services (e.g., emergency mobile psychiatric services, care coordination), which will continue to be administered by DCF

Under the HUSKY program, providers have participated as network providers with one or more of the HUSKY MCOs. The providers have either negotiated provider specific rates with the MCOs or they have operated under a fixed fee schedule, or in some cases they have done both. Under KidCare, the Departments will establish a single set of rates and fees for each provider type and service. The Departments proposed methods for establishing rates and fees balances the state's interest in having fair and efficient rate methods with the need to avoid sudden, significant disruptions in provider revenue. The purpose of this document is to outline the proposed rate and fee methods.

The Departments uses the term *rates* when referring to payments that are provider specific. The term *fee* is used for payments that are uniform across all providers and published on a fee schedule.

Summary of Services and Methods

This document includes methods for calculating rates and fees for services provided by 15 provider types as they are classified in the Connecticut Medical Assistance Program (CMAP) network and the Medicaid Management Information System (MMIS). Rates for DCF funded services (home-based psychiatric, therapeutic mentoring, etc.) are under development and will be presented at a future date.

All of the methods in this document involve the blending of utilization and expenditure data across the four HUSKY MCOs using a weighted average methodology. In some cases, weighted averages are used to create provider specific rates. Provider specific rates help ensure that payments to a given provider and service remain unchanged under the new program, assuming utilization is held constant. All proposed rates and fees in this document are based only on HUSKY units and expenditures and will apply only to services rendered under the KidCare program.

In other cases, weighted averages are used to create a uniform fee for a given service applicable to all providers in a type (e.g., skilled nursing visits provided by home health care agencies). Uniform weighted average fees would ensure that the expenditures for a given type of service are unchanged under the new program, assuming utilization is held constant. Table 1 summarizes the provider types, services, and rate methods discussed in this document.

The rates and fees that are calculated in accordance with the methodology described in this document are base rates (see page 8). BH rates under the waiver will be adjusted when rate increases are appropriated for the HUSKY MCOs. The methodology will be reviewed in advance with the Behavioral Health Oversight Committee.

Table 1.

Provider Type	Service Type	Rate/Fee
General Hospital	IP	Provider specific weighted average rate, per diem, not cost settled
	PHP	Provider specific weighted average rate, per diem
	IOP	Provider specific weighted average rate, per diem
	EDT	Provider specific weighted average rate, child only
	OP	Uniform procedure specific weighted average fee
Psych Hospital	IP	Provider specific weighted average rate
	PHP	Provider specific weighted average rate
	IOP	Provider specific weighted average rate
	EDT	Provider specific weighted average rate, child only
	OP	Uniform procedure specific weighted average fee
Psychiatric Residential Treatment Facility	IPS	Provider specific weighted average rate, child only
Mental Health Clinic	PHP	Provider specific weighted average rate
	IOP	Provider specific weighted average rate
	EDT	Provider specific weighted average rate, child only
	OP	Uniform procedure specific weighted average fee
Outpatient Clinic/School Based Health Center	OP	Uniform procedure specific weighted average fee
Alcohol/Drug Center	Rdetox	Provider specific weighted average rate
	Adetox	Provider specific weighted average rate
Methadone Maintenance	MM	Provider specific weighted average rate
Psychiatrist	OP	Uniform procedure specific weighted average fee
Advanced Practical Registered Nurse	OP	Uniform procedure specific weighted average fee

Psychologist	OP	Uniform procedure specific weighted average fee
Licensed Masters Level Clinician*	OP	Uniform procedure specific weighted average fee
Home Health	SNV/HHA	Uniform procedure specific weighted average fee
	MSW	Uniform procedure specific weighted average fee
Special Services	HBS	TBD
	BMS	TBD
	BC	TBD

* Includes Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Licensed Professional Counselor, and Licensed Alcohol and Drug Counselor

Requests for Information

Utilization and Expenditure Data

The Department of Social Services issued two requests for information (RFI) to gather information related to behavioral health service utilization and expenditures under the HUSKY program. For the *November 2003 RFI*, the Departments requested reimbursement information from the four MCOs for all behavioral health services rendered in SFY03 to HUSKY A or B enrollees in the following categories:

- General hospital - inpatient, partial hospitalization, intensive outpatient
- Psychiatric hospital - inpatient, partial hospitalization, intensive outpatient
- Psychiatric residential treatment facility - inpatient
- Alcohol and drug center - acute detoxification, ambulatory detoxification
- Mental health clinic - partial hospitalization, intensive outpatient, and outpatient
- Methadone maintenance clinic – methadone maintenance

Inpatient services were based on SFY03 dates of service while ambulatory services were based on SFY03 dates of payment. The resulting data included utilization and expenditures for each provider, service by MCO under the HUSKY program.

For the *December 2004 RFI*, the Departments requested total behavioral health ambulatory service billing volume and expenditures, by billable code, from the four MCOs. Information was reported by date of payment for SFY 2004. The following provider types were included in the RFI:

- Home Health Care Agency services
- Home Based Psychiatric Services
- General Hospital (routine outpatient only)
- Psychiatric Hospital (routine outpatient only)
- Independent Practitioners (Psychiatrists, Psychologists, Advanced Practical Registered Nurses, Licensed Clinical Social Workers, Licensed Marriage and

Family Therapists, Licensed Alcohol/Drug Counselors, Licensed Professional Counselors)

Current Rates as Reported by MCOs

The calculation of weighted average provider specific rates required current HUSKY MCO contracted rates for each provider. In March 2004, the Departments issued an RFI requesting provider-specific rates as of March 1, 2004 for each service that will be paid as a provider specific rate under KidCare. In order to crosscheck the validity of the rate data provided by the MCOs, the request for information was also sent to providers. The MCOs were contacted for confirmation if a rate appeared questionable (e.g., EDT rates for non-EDT licensed providers or reported rates inconsistent with average calculated payment based on the November 2003 RFI utilization and expenditure data). In cases where the MCO reported rate differed from the provider reported rate, further research was done to determine which rate was valid.

KidCare Rates and Fees

Provider Specific Rates

Provider specific rates were calculated using the formula in Table 2. The volume and expenditures are specific to the provider for whom the rate is being calculated. In this example, the provider has negotiated different rates with each of the four MCOs. The rates for a given provider may be and often are different than the rates negotiated by other providers for the same service.

Table 2.

MCO #1			MCO #2			MCO #3			MCO #4		
Units	Rate	Expenditures	Units	Rate	Expenditures	Units	Rate	Expenditures	Units	Rate	Expenditures
1,380	$100	$138,000	754	$90	$67,860	308	$97	$29,876	3,262	$110	$358,820

$$\frac{\text{Total Expenditures}}{\text{Total Units}} = \frac{\$594,556}{5,704} = \textbf{\$104.23}$$ **Total Weighted Average Rate**

The KidCare rates were calculated using SFY 2003 utilization (combined adult and child) and rates in effect as of March 1, 2004. In the absence of an MCO reported rate, the provider reported rate was used. When no rate was reported by either the MCO or the provider, the November 2003 MCO RFI was used to calculate an average payment rate.

For a provider in which there was no evidence that the calculated rate was based on one or more contracted rates, the current Medicaid FFS rate was given in place of the provider's weighted average. When there was no uniform Medicaid FFS rate for the service (e.g. General Hospital IP), the lowest contracted rate was used. In some cases, the calculated KidCare rate was *less than* the current Medicaid FFS rate. In these instances, the provider was defaulted to the current Medicaid FFS rate.

As noted earlier, Medicaid FFS expenditures and utilization were not included in these calculations. Services provided under Medicaid FFS will continue to be reimbursed at the Medicaid FFS rates.

Calculation of Uniform Fees

Uniform weighted average fees were calculated using the formula in Table 3 for all fee-based services except routine outpatient services provided by MH Clinics. For each calculation, the units and rates included all HUSKY MCO reported units and fees for all providers of the provider type and service in question. Services that will be subject to a fee schedule under KidCare typically were also subject to a fee schedule under the MCOs. The KidCare fees were calculated using SFY 2004 utilization and fees. One MCO reported using two fee schedules during SFY04. The fees in the second fee schedule were significantly lower then the fees in the first fee schedule. Therefore, the first fee schedule with the higher fees was used in the calculation.

If the MCOs reported no utilization for a particular therapy service code (90809, 75-80 minute visit), the fee for that code was calculated at the same percentage of Medicare as individual therapy (CPT 90806, 45-50 minute visit). For example, if the weighted average fee for 90806 provided by a psychiatrist is $84.56, and this fee is 79.66% of the Medicare fee ($106.15), then the fee for 90809 was set at 79.66% of its Medicare price for psychiatrists or $130.26.

Table 3.

MCO #1			MCO #2			MCO #3			MCO #4		
Units	Fee	Expenditures	Units	Fee	Expenditures	Units	Fee	Expenditures	Units	Fee	Expenditures
2,957	$85.46	$252,705	110	$85.00	$9,350	1,645	$80.00	$131,600	188	$110	$20,680

$$\frac{\text{Total Expenditures}}{\text{Total Units}} = \frac{\$414{,}335}{4{,}900} = \mathbf{\$84.56}$$ **Total Weighted Average Fee**

One MCO was unable to distinguish routine outpatient payments to hospitals and independent practitioners at the procedure code level. Consequently, combined hospital and independent practitioner volume and expenditure data were used to allocate volume and expenditures by procedure code. Volume and expenditures were then adjusted to match overall hospital routine outpatient expenditures, which were previously provided in the November 2003 RFI.

MH Clinic fees were calculated using a different method. HUSKY encounter data for SFY 2003 were used to determine volume and expenditures for each routine outpatient service. Volume and expenditures were then adjusted to match total MH Clinic expenditures for routine outpatient services as reported by the MCOs in the November 2003 RFI. Although one could simply use the resulting weighted average fees as the KidCare fees, the Departments based the final fee schedule on the Medicare fee schedule, which derives its fees from the relative values of the procedures in question.

Accordingly, the calculated KidCare fees were further adjusted to a uniform percentage of the Medicare fees, holding total expenditures and procedure specific volume constant. Selected procedures were exempted from this methodology in order to avoid setting rates so low in key areas that clinics would be unable to offer them. These areas include medication management, group therapy, psychological testing, and developmental testing.

Federally Qualified Health Centers (FQHCs) were not included in this analysis. Each FQHC will be reimbursed at its mental health visit rate under Medicaid FFS, which is updated annually.

Future Adjustments

The Department of Social Services generally provides capitation rate increases to the HUSKY MCOs. The HUSKY waiver and the actuarially based capitation rate range, as approved by the Centers for Medicare and Medicaid Services (CMS), provide an upper limit for such rate increases. The total costs under the HUSKY program including MCO capitation rates and fee-for-service services under the waiver (e.g., PNMI, Birth to three, and now, behavioral health) must always remain within the CMS approved waiver cost trend.

The Departments are proposing to adjust behavioral health provider rates under the waiver when rate adjustments are appropriated for the HUSKY MCOs. The Governor's budget provides for 2% in SFY06 and 0% in SFY07. The 2% applies to the budget for HUSKY MCO capitation rates and the budget for the BH carve-out. The Departments will invest the final appropriated rate increase in behavioral health rates and review any proposed rate methodology with the Behavioral Health Oversight Committee.

Appendix 1 – Table of Acronyms

ADetox = Ambulatory Detox
BC = Behavioral Consultation
BMS = Behavior Management Services/Therapeutic Mentoring
CGE = Comprehensive Global Examination
EDT = Extended Day Treatment
HBS = Home Based Services
HHA = Home Health Aid
IOP = Intensive Outpatient
IP = Inpatient
IPS = Non-Hospital Inpatient Sub-Acute
MM = Methadone Maintenance
MSW = Master of Social Work
OP = Outpatient
PHP = Partial Hospital
RDetox = Residential Detox
SNV = Skilled Nursing Visit